Proposed Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2021

On August 3, 2020, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that includes updates to payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) effective on or after January 1, 2021. At the same time, the Administration issued an Executive Order on Improving Rural and Telehealth Access. As multiple AMA staff begin an in-depth to review the 1355-page rule and the Executive Order, here are key points from our early analysis. AMA staff are also reviewing the 2021 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center proposed rule, which was released today.

PAYMENT PROVISIONS IN MPFS PROPOSED RULE

Calendar Year (CY) 2021 PFS Ratesetting and Medicare Conversion Factor

The proposed CY 2021 PFS conversion factor is $32.26, a significant decrease of $3.83 below the CY 2020 PFS conversion factor of $36.09. This represents an almost 11% decrease in the conversion factor compared to last year. The proposed CY 2021 anesthesia conversion factor is $19.96, a decrease of $2.25 from the CY 2020 conversion factor of $22.20. The CMS proposed conversion factors include the budget neutrality adjustment.

Under the Medicare Access and CHIP Reauthorization Act (MACRA), the statutory physician payment update for 2021 is zero percent. Further, the proposed rule indicates that a very steep budget neutrality adjustment will be required in 2021 to offset the payment increases for office visits and other services. The consensus of the AMA and the Federation is that the budget neutrality adjustment must be waived in light of the COVID-19 public health emergency, and the AMA strongly urges Congress to waive the budget neutrality payment reductions.

The drastic 11% reduction in the Medicare conversion factor is necessitated by proposed additional spending of $10.2 billion. The AMA/Specialty Society RVS Update Committee (RUC)'s recommendations account for only half of this additional spending, and therefore, half of the reduction. The remaining spending increases and resulting conversion factor reduction is attributed to various CMS proposals to increase valuation for specific services, as described in this table.

Increases to E/M Office Visits (99202-99215; 99XXX)	$	5,600,000,000
GPC1X E/M Office Visit Primary Care Add-on*	$	3,300,000,000
Immunization Administration (CPT codes 90460, 90461, 90471, 90472, 90473, and 90474 and HCPCS codes G0008, G0009, and G0010)	$	320,000,000
End Stage Renal Disease Services (90951-90970)	$	270,000,000
Psychiatric Diagnostic Evaluation and Psychotherapy (90791, 90792, 90832, 90834, 90837)	$	245,000,000

Initial Preventive Physical Exam and Annual Wellness Visits (G0402, G0438 and G0439)	$	194,000,000
Emergency Department Visits (CPT codes 99281-99285)	$	174,000,000
Physical and Occupational Therapy Evaluation (97161-97164, 97165-97168)	$	72,000,000
Transitional Care Management (99495-99496)	$	58,000,000

**Increase in Utilization Assumptions for GPC1X for CY2021 NPRM Relative to CY2020 Final Rule $800 million*

Table 90: CY 2021 PFS Estimated Impact on Total Allowed Charged by Specialty is included at the end of this document.

Evaluation and Management (E/M) Services

CMS proposes to implement finalized CPT descriptors, guidelines and payment rates on January 1, 2021, which will be a significant modification to the coding, documentation, and payment of evaluation and management (E/M) services for office visits. While we appreciate that CMS recognized the increases in the payment bundles for maternity care and a few other select services, the visits within the 10-day and 90-day surgical global surgical payment bundle remains unchanged. The AMA strongly supports CMS adoption of the office visit changes and continues to urge CMS to incorporate the office visit payment increases into the global surgery packages.

Medicare Telehealth Services Under Section 1834(m)

During the COVID-19 PHE, pursuant to authority granted in the CARES Act, CMS has waived the geographic and site of service originating site restrictions for Medicare telehealth services, allowing Medicare beneficiaries across the country to receive care from their homes. These flexibilities remain in effect as Health and Human Services Secretary Azar recently extended the PHE declaration through Oct. 23, 2020. CMS does not propose to permanently waive these restrictions in the PFS because it lacks authority to make this adjustment. The AMA has been aggressively lobbying Congress to remove the geographic and site of service originating restrictions, and is closely monitoring a variety of bills that would make changes to 1834(m). Permanent changes to the geographic and originating site of service restrictions will require Congressional legislation.

Medicare telehealth services have been dramatically expanded during the COVID-19 PHE. CMS has proposed to permanently keep several codes that were temporarily added to the Medicare telehealth list, including the prolonged office or outpatient E/M visit code and certain home visit services. CMS also proposes to keep additional services, including certain emergency department visits, on the Medicare telehealth list until the end of the calendar year in which the PHE ends to allow more time to study the benefit of providing these services using telecommunications technology outside the context of a pandemic. There is also language about allowing physicians to supervise non-physicians in rural areas via telehealth. AMA staff will continue to review this provision and the rest of the rule to ensure that the Medicare policies support physician-led teams.

Merit-based Incentive Payment System (MIPS)

CMS proposes to continue to gradually implement MIPS in 2021 and postpones the MIPS Value Pathways participation option until 2022 at the earliest to allow additional time for stakeholder feedback about the MVP framework. CMS is also proposing a new MIPS pathway for participants in alternative payment models (APMs) called the APM Performance Pathway (APP). The performance threshold would increase from 45 points in 2020 to 50 points in 2021, a more gradual increase instead of the 60 points as had been previously proposed. CMS also proposes to lower the weight of the Quality Category performance score from 45 percent to 40 percent of the MIPS final Score, and increase the weight of the Cost performance category from 15 percent of the MIPS final score to 20 percent. In addition, CMS plans to add telehealth services to the existing cost measures, and to use performance period benchmarks rather than historical benchmarks for quality measures, as the 2020 data may not be accurate due to the pandemic. CMS also proposes to end the CMS Web Interface as a quality reporting option for ACOs and registered groups, virtual groups, or other APM Entities beginning with the 2021 performance period.

In response to AMA advocacy, CMS established a 2020 hardship exception policy due to the COVID-19 pandemic, which allows physicians and groups to (1) opt-out of MIPS entirely and be held harmless from a penalty, or (2) opt out of any of the individual MIPS categories. The AMA will evaluate whether additional adjustments and greater flexibility are needed due to the impact of COVID-19 on patient attribution, risk adjustment, and outcomes and/or the need to extend the 2020 hardship exception policy into 2021.

Medicare Shared Savings Program

For performance year 2021, CMS is proposing that Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program would be required to report quality measure data for purposes of the Shared Savings Program via the APP, instead of the CMS Web Interface. Under this new approach, ACOs would only need to report one set of quality metrics that would meet requirements under both MIPS and the Medicare Shared Savings Program. The total number of measures in the ACO quality measure set would be reduced from 23 to 6 measures. The redesign also raises the quality performance standard for ACOs under the Shared Savings Program. ACOs would now be required to receive a Quality performance score equivalent to or above the 40th percentile across all MIPS Quality performance category scores in order to share in savings or avoid owing maximum losses.

For performance year 2020, all ACOs are deemed affected by the COVID-19 pandemic Public Health Emergency (PHE), and thus, the Shared Savings Program extreme and uncontrollable circumstances policy applies. In addition, for performance year 2020 only, CMS is proposing to waive the requirement for ACOs to field a Consumer Assessment of Healthcare Providers and Systems (CAHPS) for ACOs survey. Consequently, ACOs would receive automatic full credit for the patient experience of care measures. The AMA will continue to monitor the impact of the COVID-19 pandemic on the MSSP program and assess whether additional flexibilities and changes are needed for 2020 or 2021 performance years.

Appropriate Use Criteria Program

CMS does not address the Appropriate Use Criteria (AUC) program in the rule, which means the program would move forward with the January 1, 2021 start date. This program requires physicians to consult AUC using clinical decision support tools prior to ordering advance imaging services for Medicare beneficiaries, which is then appended to claims for those services. CY 2020 is an "Education and Operations Testing" period, during which there are no penalties for submitting claims without AUC information. The AMA has expressed concerns about the administrative burdens of this program, especially as the preparation period was curtailed by the COVID-19 pandemic, and its duplication of the Quality Payment Program.

Rural Health Model with Payment Innovation

Under the Executive Order, CMS will develop a new model to test innovative payment mechanisms with flexibilities from existing Medicare rules to allow rural healthcare providers to provide the necessary level and quality of care. The EO calls for the establishment of predictable financial payments and encourages the movement into high-quality, value-based care. The model is to be announced within 30 days of the Executive Order.

Medicare Diabetes Prevention Program (MDPP)

Although CMS has permitted many MDPP services to be provided virtually during the COVID-19 public health emergency, it still requires the first core session to be provided in-person, which prevents any new patients from participating. As the AMA had urged, the proposed rule would drop that requirement and allow all MDPP services to be delivered virtually during the current emergency as well as in future declared emergencies. CMS also proposes to allow patients to report their weight through virtual means, such as bluetooth scales. The proposed rule stops short of allowing providers of virtual-only DPP services to enroll as MDPP suppliers, however.

TABLE 90: CY 2021 PFS Estimated Impact on Total Allowed Charges by Specialty

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Allergy/Immunology	$246	5%	4%	0%	9%
Anesthesiology	$2,011	-7%	-1%	0%	-8%
Audiologist	$74	-4%	-2%	0%	-7%
Cardiac Surgery	$264	-6%	-2%	-1%	-9%
Cardiology	$6,849	1%	0%	0%	1%
Chiropractor	$759	-7%	-3%	0%	-10%
Clinical Psychologist	$824	-1%	1%	0%	0%
Clinical Social Worker	$851	-1%	1%	0%	0%
Colon And Rectal Surgery	$168	-4%	-1%	0%	-5%
Critical Care	$376	-6%	-2%	0%	-8%
Dermatology	$3,758	-1%	-1%	0%	-2%
Diagnostic Testing Facility	$813	-1%	-5%	0%	-6%
Emergency Medicine	$3,065	-5%	-1%	0%	-6%
Endocrinology	$506	11%	6%	1%	17%
Family Practice	$5,982	9%	4%	1%	13%
Gastroenterology	$1,749	-3%	-1%	0%	-5%
General Practice	$405	5%	2%	0%	8%
General Surgery	$2,041	-4%	-2%	0%	-7%
Geriatrics	$190	2%	2%	0%	4%
Hand Surgery	$245	-2%	-1%	0%	-3%
Hematology/Oncology	$1,702	9%	5%	1%	14%
Independent Laboratory	$639	-3%	-2%	0%	-5%
Infectious Disease	$653	-4%	-1%	0%	-4%
Internal Medicine	$10,654	2%	2%	0%	4%
Interventional Pain Mgmt	$932	4%	3%	0%	7%
Interventional Radiology	$497	-3%	-5%	0%	-9%
Multispecialty Clinic/Other Phys	$152	-3%	-1%	0%	-4%
Nephrology	$2,213	4%	2%	0%	6%
Neurology	$1,513	3%	2%	0%	6%
Neurosurgery	$806	-4%	-2%	-1%	-7%
Nuclear Medicine	$56	-5%	-3%	0%	-8%
Nurse Anes / Anes Asst	$1,316	-9%	-1%	0%	-11%
Nurse Practitioner	$5,069	5%	3%	0%	8%
Obstetrics/Gynecology	$633	4%	3%	0%	8%
Ophthalmology	$5,328	-4%	-2%	0%	-6%
Optometry	$1,349	-2%	-2%	0%	-5%
Oral/Maxillofacial Surgery	$78	-2%	-3%	0%	-5%
Orthopedic Surgery	$3,796	-3%	-1%	0%	-5%
Other	$47	-3%	-2%	0%	-5%
Otolarngology	$1,264	4%	3%	0%	7%
Pathology	$1,257	-6%	-4%	0%	-9%
Pediatrics	$66	4%	2%	0%	6%
Physical Medicine	$1,157	-3%	0%	0%	-3%
Physical/Occupational Therapy	$4,946	-5%	-5%	0%	-9%
Physician Assistant	$2,888	5%	3%	0%	8%
Plastic Surgery	$378	-4%	-3%	0%	-7%
Podiatry	$2,111	-1%	0%	0%	-1%
Portable X-Ray Supplier	$94	-2%	-4%	0%	-6%
Psychiatry	$1,099	4%	3%	0%	8%
Pulmonary Disease	$1,647	0%	0%	0%	1%
Radiation Oncology And Radiation Therapy Centers	$1,803	-3%	-3%	0%	-6%
Radiology	$5,253	-6%	-5%	0%	-11%
Rheumatology	$546	10%	6%	1%	16%
Thoracic Surgery	$350	-5%	-2%	-1%	-8%
Urology	$1,803	4%	4%	0%	8%
Vascular Surgery	$1,287	-2%	-5%	0%	-7%
TOTAL	**$96,557**	**0%**	**0%**	**0%**	**0%**

* Column F may not equal the sum of columns C, D, and E due to rounding.